BEFORE THE
OFFICE OF ADMINISTRATIVE HEARINGS
STATE OF CALIFORNIA

In the Matter of the Fair Hearing Request of: TIMOTHY L. Claimant, v. HARBOR REGIONAL CENTER, Service Agency.	OAH Case No. L 2006110178

DECISION

Robert S. Eisman, Administrative Law Judge, Office of Administrative Hearings, State of California, heard this matter at the Harbor Regional Center in Torrance, California, on January 12 and 31, and February 12 and 13, 2007.

Mona Z. Hanna, Attorney at Law, represented the Harbor Regional Center (HRC or service agency).

Bret R. Rayburn, Deputy Public Defender, represented Timothy L. (claimant).[1]

The record was left open for submission of written closing argument and written rebuttal closing argument. Both parties submitted their Closing Briefs on March 23, 2007, and Rebuttal Briefs on March 30, 2007. These documents are marked for identification as follows and made a part of the record in this matter.

Closing Brief for Harbor Regional Center	Exhibit 22
Rebuttal Brief for Harbor Regional Center	Exhibit 23
Claimant's Closing Argument	Exhibit M
Claimant's Rebuttal Brief	Exhibit N

[1] Claimant is referred to by his first name and the first initial of his last name to protect his privacy.

The matter was submitted on April 2, 2007.

ISSUE

The following issue is to be resolved:

Whether claimant is eligible for regional center services based on a substantial developmental disability, as defined by the Lanterman Act, due to mental retardation or a disabling condition found to be closely related to mental retardation or requiring treatment similar to that required for individuals with mental retardation.

EVIDENCE

1. Claimant exhibits 1 through 18, 20, and 21.

2. Service agency exhibits A through L.

3. Testimony of Kathleen Keon (service agency program manager), Timothy D. Collister, Ph.D. (psychologist), and Carla Back-Madruga, Ph.D. (psychologist).

FACTUAL FINDINGS

1. Timothy L. is a 37-year-old male (date of birth: May 31, 1969) who is currently incarcerated in the Los Angeles County jail. The Superior Court of California, County of Los Angeles, referred claimant for service agency evaluation for the purpose of diagnostic clarification and program planning, and ultimately to assist the court in determining whether claimant is competent to stand trial. In order to determine if claimant is eligible for regional center services, consideration was given to his medical and psychological history, described below.

2. According to claimant's mother, claimant's birth was unremarkable. He crawled at seven moths of age, walked at 10½ months of age, and talked at two to two and one-half years old. Claimant was toilet trained at two and one-half to three and one-half years of age. In early 1972, when claimant was about two and one-half years old, his mother separated from his father. Thereafter, claimant did not see his father and had few male contacts while growing up. He has a sister who is one year younger and suffers from a "mild cerebral palsy on the right side."

3. At some time prior to mid-1976, claimant started taking Ritalin 5 mg, twice daily.[2] He continued taking Ritalin until he entered the second grade in 1977.

[2] Ritalin is a mild central nervous system stimulant that is commonly prescribed as part of a treatment program for attention-deficit/hyperactivity disorder.

4. In 1974, at about age 5, claimant was evaluated at Switzer Center. The evidence did not provide the reason for or circumstances surrounding that evaluation. However, claimant received a diagnosis of minimal cerebral function[3] with a speech coordination problem.

5. Claimant's Ritalin dosage and diagnosis of minimal cerebral function imply that he suffered from Attention-Deficit/Hyperactivity Disorder (ADHD).

With respect to the associated features and disorders of ADHD, the *Diagnostic and Statistical Manual of Mental Disorders*, 2000, Fourth Edition, Text Revision (DSM-IV-TR), states, in relevant part:

> On average, individuals with Attention-Deficit/Hyperactivity Disorder obtain less schooling than their peers and have poorer vocational achievement. Also, on average, intellectual level, as assessed by individual IQ tests, is several points lower in children with this disorder compared with peers. At the same time, great variability in IQ[4] is evidenced: individuals with Attention-Deficit/Hyperactivity Disorder may show intellectual development in the above-average or gifted range. In its severe form, the disorder is markedly impairing, affecting social, familial, and scholastic adjustment. . . .

[DSM-IV-TR, p. 88.]

Care must be taken to differentiate a diagnosis of ADHD from Mental Retardation.

> Symptoms of inattention are common among children with low IQ who are placed in academic settings that are inappropriate to their intellectual ability. These behaviors must be distinguished from similar signs in children with Attention-Deficit/Hyperactivity Disorder. In children with **Mental Retardation**, an additional diagnosis of Attention-Deficit/Hyperactivity Disorder should be made only if the symptoms of inattention or hyperactivity are excessive for the child's mental age.

[DSM-IV-TR, p. 91; Emphasis in original.]

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[3] "Minimal cerebral function" is a term no longer used to describe a developmental behavioral syndrome characterized by moderate-to-severe distractibility, short attention span, hyperactivity, emotional lability, and impulsivity.

[4] Intelligence Quotient (IQ) is a score derived from one of several different standardized tests to measure intelligence.

6. During the 1975-1976 school year, claimant was in the first grade at Athanasius School, a parochial elementary school. In his first grade academic subjects, his achieved the following grades:

Religion	C
Arithmetic	D
Reading	C+
Spelling	B-
Writing	D
Science	C

Claimant received a C+ for "effort" and a B for "conduct." School records contain the remark, "Timmie is educationally handicapped – further testing during summer will determine if he is to pass."

7. In 1976, Catholic Social Services referred claimant to Gerhard Kohn, Ph.D., for a psychological evaluation because he was having trouble in school and might need to repeat the first grade. At age seven, claimant was reading at a 12-year-old level, but his comprehension was at a five-year-old level.

8. Dr. Kohn evaluated claimant in June 1976. He noted that during the evaluation, claimant was very cooperative, did not appear to be inattentive or hyperactive, and appeared to be "bright and alert." Dr. Kohn noted that claimant showed some peculiarities with his enunciation, had almost a mechanical way of speaking, and expressed little emotion.

Dr. Kohn conducted a neurological assessment of claimant. The results of a Neurological Screening Examination suggested multiple difficulties, a moderate fine bilateral motor dyskinesia[5] and marked difficulties with gross motor movements. Dr. Kohn also noted some dysdiadochokinesis[6] and some extrapyramidal and possibly cerebellar involvement[7] that appeared to be more marked on the right side than on the left. Claimant's auditory-motor functioning was also impaired. The results of a Bender

[5] Dyskinesia is difficulty or distortion in performing voluntary movements, e.g., spasmodic or repetitive motions or a lack of coordination. It can occur as a side effect of certain antipsychotic medications.

[6] Dysdiadochokinesis is the inability to execute rapidly alternating movements, particularly of the limbs.

[7] Extrapyramidal involvement refers to involuntary movements, most often affecting the mouth, lips and tongue; tremors and rigidity; body restlessness; muscle contractions and changes in breathing and heart rate. It is a more common symptom among patients taking antipsychotic medications. Cerebellar involvement refers to incoordination and imbalance.

Motor Gestalt Test indicated a mild to moderate level of central nervous system impairment. The results of a Personality Evaluation suggested that claimant was very fearful of his environment, and was over-dependent and over-protected. He tended to be worried and apprehensive.

Dr. Kohn also administered a series of psychological testing instruments, including the Wechsler Intelligence Scale for Children - Revised (WISC-R), to determine claimant's IQ, and the Wide Range Achievement Test (WRAT) to identify any learning disabilities in reading, spelling, and arithmetic.

Claimant achieved the following WISC-R IQ and scaled subtest scores, which placed him in the average range of academic ability. His scaled score of 3 on the Comprehension Subtest showed a marked deficiency in generalizing practical knowledge and experience to social situations. His other reported subtest scores indicated difficulty with long and short term memory.

Full Scale IQ (FSIQ)[8]	91	Scaled Subtest Scores	
Verbal IQ	95	Comprehension	3
Performance IQ	87	Information	6
		Object Assembly	5
		Coding	6

On the WRAT, claimant obtained the following grade-level scores (claimant had just completed the 1st grade). Dr. Kohn noted that claimant's high reading score demonstrated excellent phonetic ability but it did not accurately reflect his reading comprehension.

Subject	Grade-Month
Reading Recognition	5-3
Spelling	1-7
Arithmetic	2-1

Other tests resulted in findings that claimant's receptive processes were significantly lower than his expressive processes in the acquisition and use of language and that he showed a deficiency in discriminating reversals and rotation of figures presented in a series.

In his summary, Dr. Kohn stated:

> Timothy is a fearful child of low average intelligence whose academic achievement is slightly below expected grade level. He appears to have moderate language difficulties, particularly with receptive as

[8] The Full Scale IQ (FSIQ) is a composite score that is derived from a subject's Verbal IQ and Performance IQ.

compared to expressive language. Timothy's comprehension is low with particular difficulties in short term memory. He has some perceptual problems primarily in picking out symbols from complex patterns and with syntactic structuring. His problems with language comprehension and perception can be seen as a case of minimal cerebral dysfunction. Emotional difficulties are abundant.

Special remedial education as well as psychotherapy for emotional problems are recommended.

Dr. Kohn's impression was that claimant suffered from "adjustment reaction of childhood[9]."

9. Claimant was not required to repeat the first grade and he continued at Athanasius School in regular classes through the eighth grade. When he entered the ninth grade at Stanford Junior High School, claimant started enrollment in special education classes, which he continued until graduation from high school at age 18.

His elementary school academic grades were as follows:

Subject / Grade	2	3	4	5	6	7	8
Religion	B-	C	B	C-	C-	C+	B
Arithmetic	C	C	C+	D	D	D	F
Reading	B	C+	C+	D	D	C	C+
English	C+	B	C+	D	C	C	C
Spelling	A-	B-	B-	A	A	B+	B
History	--	C	C	D	D	C	C
Writing	D	D	C-	D	C-	C-	C
Science	C	C	C	D	D	C	D

Each year during the second through seventh grade (1977 - 1982), claimant also completed the Comprehensive Test of Basic Skills (CTBS). His CTBS total battery and subject grade-equivalent scores were as follows, demonstrating a change from delayed progression between the second and sixth grades, to marked regression in his basic skills between the sixth and seventh grades:

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/ / /

[9] An adjustment reaction (i.e., adjustment disorder), which can occur in any age group, is a psychological response to an identifiable stressor or stressors that results in the development of clinically significant emotional or behavioral symptoms (DSM-IV-TR, p. 679, 681).

Subject / Grade-Month	2-7	3-7	4-6	5-6	6-6	7-6
Total Test Battery	3-0	3-0	3-7	4-7	5-6	5-4
Reading	3-4	2-1	3-6	4-1	4-2	5-0
Language	3-6	3-3	4-4	6-6	7-3	5-7
Mathematics	2-6	3-2	3-6	4-2	6-1	5-5

10. Claimant continued taking Ritalin, 5 mg, twice daily, until he started third grade, at which time he appeared to be doing well without the drug.

11. Claimant's pediatric medical records indicate that in September 1978, a specimen of claimant's hair was analyzed and found to contain an increased level of lead and iron. However, the medical records do not indicate the level of these substances that were in the hair specimen. None of the blood tests documented in claimant's pediatric medical records indicated the presence of lead. Although claimant's mother later told a psychologist that when he was a child claimant would "chew on a window sill," there is no evidence that, as a result, he ingested lead.

12. Claimant's medical records indicate that in May 1980 he attacked his younger sister with a pair of scissors. The records note that he had previously attacked her and his behavior had been gradually worsening. It was evident he needed therapy. Claimant was referred for an electroencephalogram (EEG) to rule out whether he had a psychomotor or epileptic condition. His EEG results were normal and a subsequent neurological examination had negative results.

13. In response to a request from claimant's mother, in December 1982, at age 13 claimant was assessed by the Long Beach Unified School District to determine if he qualified for a special education program. The school district psychologist, Tacy Hunter, administered a series of psychological testing instruments, including the WISC-R and the WRAT. The results were as follows:

WISC-R

Full Scale IQ	69	
Verbal IQ	82	(Low Average)
Performance IQ	58	(Mentally Deficient)

Verbal Subtest Scores		Performance Subtest Scores	
Information	6	Picture Completion	4
Similarities	8	Picture Arrangement	4
Arithmetic	9	Block Design	4
Vocabulary	8	Object Assembly	4
Comprehension	5	Coding	2

WRAT

Subject	Grade-Month
Reading	8-5
Spelling	5-5
Mathematics	4-6

When claimant was taking the WISC-R, Ms. Hunter noted that he exhibited slow, deliberate, seemingly pre-planned movements and that he used a great deal of random trial and error. She also noted that claimant had great difficulty finding an alternate solution to a task if his original solution proved to be incorrect.

In that claimant's inordinately low scores on the WISC-R performance subtests negatively influenced the full scale score, and the 24-point difference between the Verbal and Performance scores was statistically significant, Ms. Hunter questioned the validity of the full scale score.

Ms. Hunter indicated that claimant's teachers reported claimant exhibited the following significant traits: excessive anxiety, poor ego-strength, poor physical strength, poor intellectuality, poor academics and excessive resistance.

14. By June 1983, claimant was being seen at Long Beach Mental Health Clinic because he was diagnosed as having the psychiatric disorder schizoid of adolescence.[10] He continued receiving therapy at the mental health clinic, three times per week, at least through July 1984, at which time he had already been taking the prescription drug Mellaril, 100 mg, three times per day.[11] Although claimant was on Mellaril and received ongoing therapy, he continued to exhibit violent behavior and act immature.

15. In August 1983, claimant was assessed by Cecil C. Whiting, Ph.D., a clinical psychologist, based on a referral from the Department of Social Services. Claimant was 14 years old at the time of the psychological assessment. Dr. Whiting conducted a pre-test interview of claimant and administered the WISC-R and Bender Motor Gestalt tests. Claimant's performance on the WISC-R was as follows:

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[10] Schizoid of adolescence is a personality disorder that has, as an essential feature, a pervasive pattern of detachment from social relationships and a restricted range of expression of emotions in interpersonal settings. The pattern begins by early adulthood and is present in a variety of contexts (DSM-IV-TR, p. 694).

[11] Mellaril is prescribed for the treatment of schizophrenia. Use of this drug ordinarily does not result in significant changes in cognitive abilities.

Full Scale IQ	70
Verbal IQ	69
Performance IQ	73

Verbal Subtest Scores		Performance Subtest Scores	
Information	2	Picture Completion	4
Similarities	6	Picture Arrangement	7
Arithmetic	4	Block Design	7
Vocabulary	8	Object Assembly	6
Comprehension	5	Coding	6

In his abbreviated report, Dr. Whiting diagnosed respondent as being "profoundly behavior disordered" with "borderline mental retardation." He found that claimant's behavior disorder tended to "override the issue of brain damage or mental retardation," and opined that "with appropriate therapeutic intervention, significant improvement can be seen in one year's time."

16. According to the service agency's client data base, in 1984 claimant was evaluated for regional center benefit eligibility.[12] On or about May 16, 1984, the service agency denied benefits because claimant was not found to have a developmental disability.

17. The next psychological assessment that claimant underwent was in 1996, when he was 27 years-old. This assessment was completed by Marie L. Hunter, Ph.D. (psychologist) and Lolita de Cordoba, Ph.D. (psychological assistant). Its purpose was to determine if claimant was eligible to receive funding from the Department of Social Services.

Claimant informed Dr.Hunter that he loved attending school and graduated from high school at age 18. He printed on his personal data sheet that his special abilities were "reading and watching TV." In answering whether he had any problems, he printed "mentally disabled." He also informed Dr. Hunter that after graduating from high school he resided in a board and care facility for about a year, after which he moved into his own apartment. He did not live on his own for long, but could not remember why. He then went to another board and care facility. At the time of the evaluation, he was sharing an apartment with a friend. Claimant stated that he previously had a girlfriend and they were engaged in 1989.

Claimant admitted that he sometimes heard himself saying words he did not mean to say, and he faintly exhibited characteristics of Tourette syndrome (i.e., physical movements, facial grimaces, and vulgar language).

[12] The results of the evaluation(s) used to determine eligibility are not available.

At the time of the assessment, claimant indicated that his psychiatrist prescribed four medications that he had been taking daily for a year. Besides Motrin (ibuprofin), for lower back pain, claimant was taking Dalmane,[13] Trilafon[14] (8 mg three times a day), and Congentin[15] (1 mg, twice daily).

As part of the assessment, claimant completed the Wechsler Adult Intelligence Test – Revised (WAIS-R). He obtained the following results:

Full Scale IQ	69	(Mentally Retarded)
Verbal IQ	75	(Borderline)
Performance IQ	65	(Mentally Retarded)

Verbal Subtest Scores		Performance Subtest Scores	
Information	5	Picture Completion	4
Similarities	6	Picture Arrangement	4
Arithmetic	7	Block Design	5
Vocabulary	5	Object Assembly	3
Comprehension	5	Digital Symbol-Coding	4
Digital Span	6		

Claimant's low WISC-R subtest scores indicated deficiencies with respect to putting together concrete objects, visual awareness / memory, interpretation of social situations, and hand-eye coordination.

Dr. Hunter found that claimant never held a job, would be a hazard in the workplace, may require supervision for budgeting, and would be a poor candidate for rehabilitation. She diagnosed claimant as having schizotypal personality[16] and mild mental retardation.

18. On a date not established by the evidence, claimant was arrested and sent to the Los Angeles County jail, where he currently remains, pending conclusion of court proceedings. On May 15, 2005, the District Attorney filed an Information wherein claimant was charged with five counts of violating Penal Code section 451, subdivision

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[13] Dalmane is used for the relief of insomnia.

[14] Trilafon is used for the management of the manifestations of psychotic disorders.

[15] Cogentin is used to treat symptoms of Parkinson's disease or involuntary movements due to the side effects of certain psychiatric drugs.

[16] Schizotypal personality disorder is primarily characterized by peculiarities of thinking, odd beliefs, and eccentricities of appearance, behavior, interpersonal style, and thought.

(d), arson of property, all felony offenses. As part of the criminal proceeding, the defense raised the issue of whether claimant was competent to stand trial. As part of the competency issue, claimant was referred, by court order, for evaluation to determine if he was eligible for benefits under the Lanterman Act.

19. In order to help the court resolve the competence issue, Deputy Public Defender Bret Rayburn referred claimant to Clara Back-Madruga, Ph.D., for evaluation. Dr. Back-Madruga is a psychologist who is Assistant Professor of Psychiatry and Director of the Neuropsychology Service, Rand Schrader Health and Research Center, Keck School of Medicine, University of Southern California. She has been licensed in California since 1997. Dr. Back-Madruga does not assess children as part of her practice; she assesses adolescents (i.e., above age 14-15) and adults. During her internship and post-doctoral work, Dr. Back-Madruga assisted the Public Defender's office in cases where mental retardation and competency to stand trial were at issue.

On June 23 and 26, 2006, Dr. Back-Madruga performed a neuropsychological evaluation of claimant. The objective of her evaluation was to determine if claimant had a developmental disability and if so, whether he was competent to stand trial.

As part of her evaluation, Dr. Back-Madgruga interviewed claimant and his mother, and reviewed claimant's Catholic school records, the psychological report by Dr. Kohn, the Long Beach Unified School District's psychologist's report, and the evaluations that were completed by both Dr. Cecil Whiting and Dr. Hunter. She also administered a series of tests, including the Wechsler Adult Intelligence Scale – Third Edition (WAIS-III) and the Wide Range Achievement Test – Fourth Edition (WRAT-4).

When Dr. Back-Madruga interviewed claimant's mother, claimant's mother reported, in pertinent part, that when claimant was a child, she spent a lot of time teaching him to read, and while he could read words, claimant did not comprehend the material. She estimated that claimant functioned around the level of a 6 to 8-year-old and had always had trouble learning. She also told Dr. Back-Madruga that at age 14, claimant ran into a plate glass window and "cut up his face," but denied he suffered from a concussion.

During her interview with claimant, claimant informed Dr. Back-Madruga that "he smoked a 'little bit' of marijuana two or three times per week over the last couple of years" and that his current medications included Seroquel[17], Klonopin[18], and Zoloft.[19]

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[17] Seroquel is a psychotropic medication used to treat various psychiatric disorders, including schizophrenia, bipolar disorder, and the manic phase of manic-depression.

[18] Klonopin is used to treat seizures and panic disorder. Since Klonopin produces central nervous system depression, patients receiving this drug should not engage in hazardous activities requiring mental alertness.

He also told her that he was “a little paranoid at times” and suffered from depression. Claimant reported he never held a formal job, but volunteered in the past, working as a cashier in the high school student store and cafeteria and acting as a high school "volunteer recreation aide." Although he completed driver's training in high school, claimant does not drive or have a driver’s license because he can not afford to buy a car.

Dr. Back-Madruga found claimant to be “polite and cooperative and somewhat childlike in his interactions” and was “oriented to person, place, and time.” Claimant’s thought processes were somewhat slowed and at times tangential. His language comprehension of structured task instructions was good, but his comprehension and discussion of concepts was decreased. Claimants speech was fluent.

Dr. Back-Madruga found that claimant’ cognitive functioning was intact. His performance on the WAIS III and WRAT-4 were as follows:

WAIS-III

Full Scale IQ	68	(extremely low for age)
Verbal IQ	72	(borderline for age)
Performance IQ	69	(extremely low for age)

Verbal Subtest Scores		Performance Subtest Scores	
Information	5	Picture Completion	4
Similarities	4	Picture Arrangement	4
Arithmetic	6	Block Design	6
Vocabulary	4	Digit Symbol-Coding	5
Comprehension	6	Matrix Reasoning	6
Digit Span	7		

WRAT-4

	Scaled Score	Grade-Month
Reading	61	12-5
Spelling	44	12-9
Mathematics	36	6-1

Based on her evaluation of claimant, Dr. Back-Madruga found that claimant’s test scores appeared to accurately reflect his current level of cognitive functioning. He was functioning in the extremely low range of general intellectual ability, and was significantly impaired in essentially all cognitive domains, with the exception of motor speed and dexterity, and immediate verbal attention. Claimant’s adaptive functioning

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[19] Zoloft is used for the treatment of a number of mood and anxiety disorders including depression, social anxiety disorder, posttraumatic stress disorder, panic disorder, and obsessive-compulsive disorder.

was deficient in all assessed areas. In her report dated July 20, 2006, Dr. Back-Madruga stated, in pertinent part:

> Neuropsychological testing revealed significant impairment in essentially all cognitive domains with the exception of motor speed and dexterity and immediate verbal attention. Specifically, moderate to marked impairment was documented in executive problem solving skills, verbal memory, nonverbal (visual) memory, 3 of 4 tests of sustained attention and information processing speed, language skills (e.g., confrontation naming, vocabulary range, and verbal fluency), and visual-spatial-constructional skills. Category language fluency was mildly impaired.

Dr. Back-Madruga used the Vineland-II adaptive Behavior Scale to interview claimant's mother and assess claimant's adaptive functioning. Dr. Back-Madruga found that claimant's overall Adaptive Behavior Composite was low. In terms of the domain scores, a severe deficit was documented in communication and daily living skills. His score on the socialization domain was also severely low, as indicated below.

Assessment	Standard / Raw Score	Percentile / Age Equivalent
Composite Adaptive Behavior	20 (standard)	<1st percentile
Communication Skills Domain	21 (standard)	<1st percentile
Receptive Skills	26 (raw)	2.6 years
Expressive	95 (raw)	5.11 years
Written	38 (raw)	9.6 years
Daily Living Skills Domain	34 (standard)	<1st percentile
Personal	67 (raw)	6.7 years
Domestic	14 (raw)	5.5 years
Community	56 (raw)	9.0 years
Socialization Domain	20 (standard)	<1st percentile
Interpersonal Relationships	45 (raw)	3.5 years
Play and Leisure Time	43 (raw)	5.7 years
Coping Skills	14 (raw)	2.6 years

Dr. Back-Madruga diagnosed respondent as having "mild mental retardation with associated deficits in multiple cognitive domains." She found that "depression and/or psychosis may be exacerbating his neuropsychological deficits, but alone would not account for the extent and severity of the dysfunction." She also found that "some of his psychiatric medications are sedating which may have negatively impacted his performance on measures of sustained attention/speed and memory." Dr. Back-Madruga

concluded that due to his mental retardation and extensive impairment in neuropsychological functioning, claimant was "mentally incompetent to stand trial."

20. Dr. Back-Madruga testified that in order to differentiate mental retardation from a co-morbid mental retardation and psychological condition, one primarily focuses on IQ test results, the age of deficit onset, and additional adaptive deficits. With solely a psychiatric disorder, one would not see "global depression" in IQ test scores. Co-morbid conditions are not uncommon. Dr. Back-Madruga testified that an individual with mild mental retardation (i.e., a FSIQ score of 55-70 $\pm$ 5) may acquire academic skills up to about the 6th grade level. However, academic skills above the 6th grade level is not an exclusion criteria for mild mental retardation and such a person could even earn a high school diploma, depending on the school district.

Dr. Back-Madruga could not explain certain test results, such as the claimant's IQ scores, as reported by Dr. Kohn in 1976, or the significant scatter and significantly different verbal and performance and performance IQ scores in the WISC-R test administered by LBUSD in December 1982. She appeared quick to discount or find non-determinative any test scores or academic achievement that did not support her conclusion that claimant has mild mental retardation. However, Dr. Back-Madruga admitted that if claimant's early IQ test scores were accurate, something must have happened to cause the decrease in his scores. She proposed that the cause of the decreased IQ scores was that when claimant was young and chewed on a windowsill, he might have ingested lead to a degree that caused psycho-neuro impairment and mental retardation. Since there is no medical or other evidence that claimant ingested lead as a child, Dr. Back-Madruga opined that it is possible that claimant ingested lead, but that it was not reported and/or documented. She further testified that claimant's decrease in cognitive functioning between 1976 and 1983 could only be caused by lead ingestion.

Dr. Back-Madruga did not review claimant's pediatric or mental health medical records as part of her neuropsychological evaluation. However, during the administrative hearing, she had an opportunity to review claimant's pediatric medical records for the period April 1, 1976 through December 9, 1986. Repeated references therein to claimant's treatment at Long Beach Mental Health did not sway or lead Dr. Back-Madruga to question her diagnosis of mental retardation.

When she evaluated claimant, Dr. Back-Madruga was not aware of the service agency benefits exclusion criteria in California Code of Regulations, title 17, section 54000, subdivision (c), and did not assess claimant for a psychiatric disorder because that was not the purpose of her evaluation. However, during the administrative hearing, Dr. Back-Madruga testified that she believes claimant has a psychotic or mood disorder, but could not determine if claimant was schizophrenic, had a personality disorder, or a depressive and/or psychotic condition. She did opine that claimant exhibits characteristics of paranoia, delusional disorder, schizophrenic affective disorder, psychiatric disorder – not otherwise specified, shared psychotic disorder, substance induced psychiatric disorder, and/or depressive disorder with psychotic features. She

believes claimant probably has a psychiatric disorder or mood disorder with psychotic features.

21. On September 18, 2006, respondent underwent another psychological evaluation. This evaluation was done by Timothy D. Collister, Ph.D., a clinical psychologist, who has been licensed in California since 1992. This evaluation was based on a referral from Robert Vargas, Law Enforcement Liaison with the South Central Los Angeles Regional Center, for "purposes of diagnostic clarification and program planning." The Superior Court Judge handling claimant's case ordered the evaluation.

As part of the evaluation, Dr. Collister interviewed claimant, reviewed the prior evaluations of claimant by Dr. Kohn, Long Beach Unified School District, Dr. Whiting, Dr. Hunter, and Dr. Back-Madruga, and claimant's school records. He also administered tests, including the WAIS-III and Wide Range Achievement Test – Revision 3 (WRAT-3).[20]

One report reviewed by Dr. Collister, which was not referred to in any of the prior psychological evaluation reports, was a physician's "R.T.D.S. Report," dated August 31, 1983, by Harry H. Gondo, M.D. Dr. Collister reported that Dr. Gondo saw claimant for a diagnostic evaluation on January 17, 1983, when claimant was approximately 13½ years old, and at which time claimant described "a history of depression, suicidal talk, fire setting incidents, growing violent and dangerous tendencies (for instance, he once threw a scissors at his sister's face)." Dr. Gondo noted that claimant had no friends, and usually sits at home, watching television. Claimant's verbalizations were so slow and halting as to suggest at least perplexity, if not confusion. Due to claimant's socialization deficiencies, detachment from his environment, and "halting stream of thought," Dr. Gondo's final diagnosis of claimant was "schizoid disorder of adolescence." The prognosis for claimant was guarded and his functional limitations were considerable.

During the interview, claimant informed Dr. Collister about his background, education, and current and past problems. He informed Dr. Collister that he attended St. Athanasious School, a Catholic elementary institution, Stanford Middle School and graduated from Jordan High School in 1987. Claimant said he received special education resources for two to three hours daily from the ninth grade on, but never received special education resources throughout the day. Since age 18, claimant resided in board and care facilities and received Social Security benefits that he said were "related to paranoia and

[20] When he evaluated claimant, Dr. Collister was not aware that the WRAT-4 had been published and was available. The significant difference between the WRAT-3 and WRAT-4 is that the WRAT-4 includes an assessment of the subject's sentence comprehension.

he schizophrenia[21]." Claimant twice attempted to live on his own, but eventually returned to board and care.

With respect to his medications, claimant told Dr. Collister that he was taking Klonopin for anxiety and Zoloft for depression. Prior to his incarceration, i.e., when residing in a Orange Community Care, a board and care facility, he received his medications from a psychiatrist. Claimant said his working diagnosis was, "Just a little paranoia. Maybe a little schizophrenic."

When Dr. Collister asked about psychotic features, claimant told him about voices that he heard, which sometimes involved commands. These auditory hallucinations began when claimant was a teenager and, in the beginning, included commands to hurt himself. At the time of this evaluation, claimant still continued to have auditory hallucinations, including commands, and paranoid ideation about perhaps two or three days per week.

Claimant indicated that he had normal concentration and played cards such as "Spades" and "Gin Rummy," and occasionally won. He understood that he was charged with arson for setting trash on fire and some property damage to wooden fences. He also understood that he had not been sentenced and knew what it meant to plead "guilty" and "not guilty," but did not understand the concepts of a "no contest" plea and "plea bargaining."

Claimant's performance on the WAIS-III and WRAT-3 were as follows:

WAIS-III

Full Scale IQ	69	(upper mild retardation)
Verbal IQ	69	(upper mild retardation)
Performance IQ	74	(mid-borderline)

[21] Paranoia is a general term used to describe suspiciousness or mistrust that is either highly exaggerated or not warranted at all.

Schizophrenia is major psychiatric illness. It results from a severe, chronic, and disabling disturbance of the brain that causes distorted thinking, strange feelings, unusual behavior, and unusual use of language and words. Symptoms in adolescents may include a distorted perception of reality, confused thinking, detailed and bizarre thoughts and ideas, suspiciousness and/or paranoia, hallucinations, delusions, extreme moodiness, severe anxiety and/or fearfulness, difficulty in performing schoolwork, social withdrawal, and significant regression to begin acting like a younger child.

Verbal Subtest Scores		Performance Subtest Scores	
Information	4	Picture Completion	4
Similarities	6	Block Design	6
Arithmetic	6	Digit Symbol-Coding	5
Vocabulary	4	Matrix Reasoning	8
Comprehension	3		
Digit Span	6		

WRAT-3

	Scaled Score	Equivalent
Reading	88	High School
Spelling	98	High School
Mathematics	80	6th Grade

Dr. Collister noted that claimant's academic performance on the WRAT-3 were "very strong." It is noteworthy that claimant correctly wrote such words as "reference," "physician," "prejudice," "equipment," "museum," "illogical," "familiar," and "necessity." He was also able to read words such as "mosaic," "audacious," "protuberance," and "factitious." Claimant performed problems subtracting two numbers with decimal points, division problems with three numbers in the denominator and one in the numerator, converted one and one-half hours into minutes, performed multiplication problems with 2 three-digit numbers, and completed a problem involving percentages, i.e., that three-quarters equaled 75 percent.

During the interview, claimant was able to effectively communicate with Dr. Collister, and "showed a rather surprising vocabulary. Dr. Collister noted that claimant used precise speech. For example, when claimant looked at a picture of a train, he was able to define the mechanism attaching the cars as a "coupler."

Dr. Collister found that starting in claimant's early teenage years, claimant's cognitive functioning started diminishing, and he related that change to the emergence of acute psychiatric difficulty. Dr. Collister argued that claimant's psychiatric difficulty has impacted his cognitive functioning since claimant's teenage years.

Dr. Collister did not assess claimant's adaptive functioning because he did not have a "historian," such as claimant's mother, present to provide specific information.

Dr. Collister gave claimant a DSM-IV diagnosis of Psychotic Disorder, Not Otherwise Specified, and Depressive Disorder, Not Otherwise Specified.

Dr. Collister did not diagnose claimant as being mentally retarded. He did not make that diagnosis because of the contradictory information that was found in this and prior evaluations of claimant. In particular, the IQ scores that claimant obtained after his evaluation by Dr. Kohn were not consistent with claimant's academic performance. If claimant was mentally retarded, he would not have demonstrated achievement in the

average to low average range. Dr. Collister suggested that there are factors, other than mental retardation, that impacts claimant's cognitive functioning. This is supported by the fact that levels of cognitive function have shown a progressive deterioration to current levels, which are now fairly consistent. Dr. Collister found that "scores dropped radically for cognitive function by about age 13 to 14, then have remained relatively stable since, roughly at the upper end of the mild range of delay. He believes that the deterioration of claimant's cognitive functioning is most likely the result psychosis. Dr. Collister reported:

> It is important to consider the fact that [claimant's] psychiatric difficulty began to unfold by his account in early teenage years. This would place psychiatric difficulty, with auditory hallucinations and command aspects, as well as suicidal ideation, at the very time that measured cognitive function began to decline, even though academic achievement has remained fairly strong. With that temporal relationship, between diminishing cognitive function in relation to the emergence of acute psychiatric difficulty including psychotic features and paranoia, requiring substantial psychotropics, and the presence of academic achievement that has remained fairly strong, indeed, in the low average range by the current results, one would argue that the psychiatric difficulty including underlying internal processing, turmoil, paranoia, and also medication effects, have impacted cognitive function since. This would argue against a strict diagnosis of mental retardation, which is not offered here.

22. The following chart indicates how claimants WISC/WAIS and WRAT scores changed over time:

Evaluator:	Kohn	LBUSD	Whiting	Hunter	Back-Madruga	Collister
Age:	7	13½	14	27	37	37
WISC / WAIS						
Full Scale IQ	91	69	70	69	68	69
Verbal IQ	95	82	69	75	72	69
Performance IQ	87	58	73	65	69	74
Verbal Scaled Scores						
Information	6	6	2	5	5	4
Similarities	--	8	6	6	4	6
Arithmetic	--	9	4	7	6	6
Vocabulary	--	8	8	5	4	4
Comprehension	3	5	5	5	6	3
Digital Span	--	--	6	7	6	--

Evaluator:	Kohn	LBUSD	Whiting	Hunter	Back-Madruga	Collister
Performance Scaled Scores						
Picture Completion	--	4	4	4	4	4
Picture Arrangement	--	4	7	4	4	--
Block Design	--	4	7	5	6	6
Object Assembly	5	4	6	3	--	--
Coding	6	2	6	4	5	5
Matrix Reasoning	--	--	--	--	6	8
WRAT						
Reading	5-3	8-5	--	--	61 (12-5)	88 (HS)
Spelling	1-7	5-5	--	--	44 (12-9)	98 (HS)
Mathematics	2-1	4-6	--	--	36 (6-1)	80 (6th)

23. Kathleen Keon, a regional center Program Manager, testified that after considering Dr. Collister's psychological evaluation, Dr. Kohn's evaluation when claimant was age 7, and the prior reports from other clinicians, including Dr. Back-Madruga, the service agency notified claimant by letter dated October 6, 2006, that he was not eligible for regional center services because the service agency interdisciplinary eligibility team[22] determined that he did not have a developmental disability. Although the interdisciplinary team agreed that claimant's disability originated prior to the age of 18 and was likely to continue indefinitely, they did not consider claimant as being eligible for benefits due to mental retardation or the "fifth category" because team members concluded that claimant's disabilities were based solely on a psychiatric condition. The team did not make any conclusions with respect to whether claimant had a learning and/or physical disability.

The team's assessment notes indicated the following:

a. Expressive language: Claimant could retain a conversation, tell a story, and recognize the meaning of words such as "audacious," "protuberance" and "factitious."

b. Receptive language: Claimant is responsive and can follow directions and a complex story.

c. Written language: Claimant is able to read, write and spell at the high school equivalent.

[22] Claimant's eligibility review was conducted by a service agency interdisciplinary team that consisted of Sri Moedjono, , physician; Kathleen Keon, Program Manager; Elaine Ito, HRC psychologist; and Sylvia Young, HRC psychologist.

d. Learning: Claimant's current FSIQ is 69, which is unexpected, considering his academic achievement levels, which are not expected of one who is mentally retarded. IQ testing at age 7 resulted in a significantly higher FSIQ, as well as verbal and performance sub-scores.

e. Self-care: Claimant is able to care for his personal hygiene and grooming needs. However, he can not cook if measurements are required and has trouble making monetary transactions. He is not able to identify simple household dangers.

f. Mobility: Claimant has no mobility or fine motor impairments

g. Self-direction: Claimant is able to follow home and community rules. He will interact in group activities, but often does not understand spatial boundaries and complex social cues. He experiences paranoid ideation and auditory hallucinations, and may have underlying depression.

h. Capacity for independent living: He is unable to manage money and does not schedule appointments or keep a calendar. He accesses public transportation for travel.

i. Capacity for economic self-sufficiency: Claimant has never retained employment.

LEGAL CONCLUSIONS

1. Jurisdiction was established to proceed in this matter, pursuant to Welfare and Institutions Code section 4710 et seq.

2. The Legislature has enacted a comprehensive statutory scheme known as the Lanterman Developmental Disabilities Services Act (Lanterman Act; Welf. & Inst. Code, § 4500 et seq.) to provide facilities and services to meet the needs of those with developmental disabilities, regardless of age or degree of handicap. Such services include locating persons with developmental disabilities (Welf. & Inst. Code, § 4641); assessing their needs (Welf. & Inst. Code, §§ 4642-4643); and, on an individual basis, selecting and providing services to meet such needs (Welf. & Inst. Code, §§ 4646-4647). The purpose of the statutory scheme is twofold: to prevent or minimize the institutionalization of developmentally disabled persons and their dislocation from family and community (Welf. & Inst. Code, §§ 4501, 4509, 4685), and to enable them to approximate the pattern of everyday living of nondisabled persons of the same age and to lead more independent and productive lives in the community (Welf. & Inst. Code, §§ 4501, 4750-4751).

3. In this case, claimant is seeking eligibility for services from the service agency. Therefore, the burden is on claimant to establish that he meets the eligibility criteria established in the Lanterman Act.

4. Welfare and Institutions Code section 4512, subdivision (a), states:

> "Developmental disability" means a disability that originates before an individual attains age 18 years, continues, or can be expected to continue, indefinitely, and constitutes a substantial disability for that individual. As defined by the Director of Developmental Services, in consultation with the Superintendent of Public Instruction, this term shall include mental retardation, cerebral palsy, epilepsy, and autism. This term shall also include disabling conditions found to be closely related to mental retardation or to require treatment similar to that required for individuals with mental retardation, but shall not include other handicapping conditions that are solely physical in nature.[23]

5. California Code of Regulations, title 17, section 54000, subdivision (c), lists criteria, which if met, would exclude a consumer with a handicapping condition from eligibility for service agency benefits under the Lanterman Act. A developmental disability shall not include handicapping conditions that are any of the following:

> (1) Solely psychiatric disorders where there is impaired intellectual or social functioning which originated as a result of the psychiatric disorder or treatment given for such a disorder. Such psychiatric disorders include psycho-social deprivation and/or psychosis, severe neurosis or personality disorders even where social and intellectual functioning have become seriously impaired as an integral manifestation of the disorder.
>
> (2) Solely learning disabilities. A learning disability is a condition which manifests as a significant discrepancy between estimated cognitive potential and actual level of educational performance and which is not a result of generalized mental retardation, educational or psycho-social deprivation, psychiatric disorder, or sensory loss.
>
> (3) Solely physical in nature. These conditions include congenital anomalies or conditions acquired through disease, accident, or faulty development which are not associated with a neurological impairment that results in a need for treatment similar to that required for mental retardation.

6. California Code of Regulations, title 17, section 54001, states, in pertinent part:

/ / /

[23] This latter condition is commonly referred to as the "Fifth Category."

(a) "Substantial disability" means:

(1) A condition which results in major impairment of cognitive and/or social functioning, representing sufficient impairment to require interdisciplinary planning and coordination of special or generic services to assist the individual in achieving maximum potential; and

(2) The existence of significant functional limitations, as determined by the regional center, in three or more of the following areas of major life activity, as appropriate to the person's age:

(A) Receptive and expressive language;
(B) Learning;
(C) Self-care;
(D) Mobility;
(E) Self-direction;
(F) Capacity for independent living;
(G) Economic self-sufficiency.

(b) The assessment of substantial disability shall be made by a group of Regional Center professionals of differing disciplines and shall include consideration of similar qualification appraisals performed by other interdisciplinary bodies of the Department serving the potential client. The group shall include as a minimum a program coordinator, a physician, and a psychologist.

(c) The Regional Center professional group shall consult the potential client, parents, guardians/conservators, educators, advocates, and other client representatives to the extent that they are willing and available to participate in its deliberations and to the extent that the appropriate consent is obtained.

7. There is no evidence that the regional center's interdisciplinary eligibility team, as part of their eligibility analysis, consulted with claimant, claimant's mother, or the Deputy Public Defender who represents claimant in both this matter and claimant's pending criminal proceeding.

Mental Retardation

8. Pursuant to DSM-IV-TR, three criteria must be met before a diagnosis of mental retardation can be rendered. There is no diagnosis of mental retardation if any of the criteria are not found.

The essential feature of Mental Retardation is significantly subaverage general intellectual functioning (Criterion A) that is

> accompanied by significant limitations in adaptive functioning in at least two of the following skill areas: communication, self-care, home living, social/interpersonal skills, use of community resources, self-direction, functional academic skills, work, leisure, health, and safety (Criterion B). The onset must occur before age 18 years (Criterion C).
>
> *General intellectual functioning* is defined by the intelligence quotient (IQ or IQ-equivalent) . . . . Significantly subaverage intellectual functioning is defined as an IQ of about 70 or below . . . . It should be noted that there is a measurement error of approximately 5 points in assessing IQ, although this may vary from instrument to inetrument (e.g., Wechsler IQ of 70 id considered to represent a range of 65-75). Thus it is possible to diagnose Mental Retardation in individuals with IQs between 70 and 75 who exhibit significant deficits in adaptive behavior. . . . When there is a marked discrepancy across verbal and performance scores, averaging to obtain a full-scale IQ score can be misleading.
>
> *Adaptive functioning* refers to how effectively individuals cope with common life demands and how well they meet the standards of personal independence expected of someone in their particular age level, group, sociocultural background, and community setting.

[DSM-IV-TR, p. 41.]

There are four degrees of mental retardation severity, reflecting various levels of intellectual impairment. "Mild" mental retardation is characterized by an IQ level of 50-55 to approximately 70.

> As a group, people with this level of Mental Retardation typically develop social and communication skills during the preschool years (ages 0-5 years), have minimal impairment in sensorimotor areas, and often are not distinguishable from children without Mental Retardation until a later age. By their late teens, they can acquire academic skills up to approximately the sixth-grade level. During their adult years, they usually achieve social and vocational skills adequate for minimum self-support, but may need supervision, guidance, and assistance, especially when under unusual social or economic stress. With appropriate supports, individuals with Mild Mental Retardation can usually live successfully in the community, either independently or in supervised settings.

[DSM-IV-TR, p. 43.]

"Individuals with Mental Retardation have a prevalence of comorbid mental disorders that is estimated to be three to four times greater than in the general population." (DSM-IV-TR, p. 45). In approximately 30-40 percent of mentally retarded

individuals seen in a clinical setting, it is not possible to determine a clear etiology for the mental retardation. The major predisposing factors include heredity, early alterations of embryonic development, environmental influences, mental disorders (e.g. autistic disorder and other pervasive developmental disorders), pregnancy and perinatal problems, and general medical conditions acquired in infancy or childhood.

Contrary to the exclusion criteria established in California Code of Regulations, title 17, section 54000, subdivision (c), "[t]he diagnostic criteria for Mental Retardation do not include an exclusion criterion; therefore, the diagnosis should be made whenever the diagnostic criteria are met, regardless of and in addition to the presence of another disorder." (DSM-IV-TR, p. 47). "Mental retardation often accompanies Pervasive Developmental Disorders." Pervasive Developmental Disorders would qualitatively affect the development of reciprocal social interaction and the development of verbal and nonverbal skills.

9. With the exception of Dr. Whiting's impression that, at age 14, claimant's profound behavior disorder overrode his borderline mental retardation, prior to attaining the age of 18, claimant had not been diagnosed as being mentally retarded**.** The only psychological or psychiatric conditions that were recognized were emotional problems related to adjustment reaction of childhood (Dr. Kohn) and schizophrenia of adolescence (as note in claimant's medical records). The IQ scores attained during claimant's assessment by Dr. Kohn did not support a diagnosis of mental retardation. Although the Full-Scale IQ score (69) attained during the Long Beach Unified School District assessment fell within the range for mild mental retardation, that score was questioned as a result of the significant variability in the subtest scores (Verbal IQ = 82, Performance IQ = 58).

10. None of those who evaluated claimant before the age of 18 specifically found that his disabilities were solely due to one or more specific psychiatric disorders. As indicated by Dr. Back-Madruga, the general array of deficits, which included both cognitive[24] and adaptive deficiencies, was too broad to reasonably expect that all of them resulted from a psychiatric disorder. From an early age, claimant had problems with respect to his adaptive functioning. Assuming the validity of the test results obtained and findings made by Dr. Kohn, Tacy Hunter, and Dr. Whiting, "something" happened to cause claimant's cognitive abilities to significantly decrease prior to the age of 18. The evidence demonstrates changes in claimant's cognitive abilities over time. However, it is inappropriate to conclude that the causal factor was solely psychiatric in nature. Such a conclusion would be merely speculative, especially given the possibility of co-morbid conditions (e.g., a psychiatric disorder combined with a learning and/or physical disorder, where none, alone, would result in claimant's global cognitive deficits.)

[24] Cognitive means "the ability of an individual to solve problems with insight, to adapt to new situations, to think abstractly and to profit from experience." (Cal. Code Regs., tit. 17, § 54002.)

11. Claimant did not establish by a preponderance of the evidence that prior to the age of 18, he was mentally retarded. Diverse test scores during claimant's childhood and adolescence demonstrated changes that one would not expect from someone who is mentally retarded. While academic achievement might vary, one would expect global depression of scores each time claimant was tested before the age of 18. Additionally, one would not expect someone who is mentally retarded to be able to graduate from high school, on schedule, and demonstrate, in at least in some academic areas, achievement that would reasonably be expected of a high school graduate. After age 18, claimant consistently obtained IQ scores in the mild mentally retarded range. However, that alone does not establish that claimant was mentally retarded prior to the age of 18. Although claimant exhibited cognitive and adaptive deficits at that time, given the totality of the evidence in this matter, including the two comprehensive psychological assessments that were done by Dr. Back-Madruga and Dr. Collister some 19 years after claimant's 18th birthday, and the ADHD, evolving psychiatric conditions, and treatment with psychotropic medications that were a part of claimant's childhood and adolescence, claimant did not establish that he met the criteria for a formal diagnosis of mental retardation prior to the age of 18.

12. Both claimant and the service agency relied upon published research pertaining to psychiatric conditions and IQ scores. These studies, which were received solely as administrative hearsay, were based on controlled factors, including population sampling. However, none of the studies were based on a subject that specifically matched claimant's characteristics, including his psychiatric condition, level of academic achievement, and the combination of psychotropic medications that he consumed. To that extent, the published research was given limited weight as it relates to this matter.

One peer reviewed study, "No, It Is Not Possible to Be Schizophrenic Yet Neuropsychologically Normal," by Christopher M. Wilk, et al., 2005, was received into evidence for the limited purpose of establishing a basis for Dr. Back-Madruga's opinions. The authors found, in relevant part:

> The evidence presented in this article indicates that scoring in the normal range on FSIQ does not preclude neuropsychological abnormalities in schizophrenia. Rather, these data, confirm the notion that cognitive abnormalities are core features of schizophrenia, because they affect even the highest functioning patients with the illness. . . . the total schizophrenia sample in this analysis is probably not comparable in FSIQ or the WAIS-III/WMS-III index scores to a random sample of the population of all patients with schizophrenia.

A second peer-reviewed study, "Cognitive Development in Schizophrenia: Follow-Back from the First Episode," by Robert M. Bilder, et al., 2006, was also received into evidence for the limited purpose of establishing a basis for Dr. Back-Madruga's opinions. The authors found, in relevant part:

> The results demonstrate that objective test scores obtained from the academic record of individuals who would later go on to develop schizophrenia were significantly lower than those of their peers who did not develop mental illness. These differences were apparent already in the first grade . . . . The effect does not appear to be subtle, with the difference approximately 1 grade equivalent in the 1st grade . . . .
>
> The near parallel curves in grade equivalent scores between patients and healthy volunteers suggest that the significant difference in achievement are maintained and may widen slightly over the years through high school. . . . [¶] . . . [¶]
>
> There are multiple limitations to the current findings.

In a third study, "Differential Diagnosis of Mental Subnormality and Abnormality: The Contribution of Psychometrics," by Stanley R. Kay, 1999, the author proposed a battery of tests to help make a differential diagnosis between developmental mental subnormality (mental retardation) and defective intelligence of nondevelopmental origin, which is "typically the consequence of the disorganized state or more insidious regression occurring in certain psychotic conditions, most notably schizophrenia." He further contends that both mentally retarded subjects and psychotics, "very often exhibit failures in adaptive functioning due to psychiatric rather than developmental reasons." The cognitive impairment under both circumstances can be highly similar. Dr. Back-Madruga disagreed with the author's contentions.

13. To the extent that both parties made certain assumptions regarding claimant's childhood and adolescence, which resulted from varying degrees of speculation, neither party established, by a preponderance of the evidence, that claimant's disabilities were either solely due to a psychiatric condition or that he was mentally retarded.

Fifth Category

14. Pursuant to Welfare and Institutions Code section 4512, subdivison (a), eligibility for regional center services under the fifth category requires a determination as to whether an individual functions in a manner that is similar to that of a person with mental retardation or requires treatment similar to that required by individuals with mental retardation.

15. The Legislature has delegated to the Department of Developmental Services and regional centers the responsibility for assessing eligibility and providing services to the developmentally disabled. In *Mason v. OAH* (2001) 89 Cal.App.4th 1119, the appellate court clarified that there was no legislative intent to provide a detailed definition of the Fifth Category in the Lanterman Act, deferring to the

professionals of the Regional Center Eligibility Team to make the decision on eligibility after considering information obtained through the assessment process.

In *Mason*, an administrative law judge upheld a service agency's determination that the claimant was not developmentally disabled and thus was ineligible for regional center services. The claimant claimed that under the Lanterman Act, he had a disabling condition that was closely related to mental retardation and required treatment similar to that provided to those who are mentally retarded. The service agency disagreed because the claimant's IQ and adaptive functioning scores, which together determine whether an individual is mentally retarded, fell within the low average range. The claimant did not provide competent testimony that he required treatment similar to that required by mentally retarded individuals. Claimant's experts did not have expertise in that area and no evidence was received that the claimant received any programming or classes designed for children with mental retardation. Additionally, the claimant's expert witness did not recommend specific treatments that were similar to that required by mentally retarded individuals. The trial court found that the claimant did meet the Fifth Category criteria, but the appellate court reversed that judgment.

16. To answer the question of Claimant's eligibility under the Fifth Category, several requirements must be met. At any point, a failure to satisfy a requirement will result in a conclusion of no eligibility. If all requirements are satisfied, eligibility is found, unless the service agency establishes exclusion under California Code of Regulations, title 17, section 54000, subdivision (c).

A developmental disability must exist. That disability must be determined to fit into a category of eligibility. The condition must also constitute a substantial disability or handicap, and must not be solely from an excluded condition.

"Disabling conditions found to be closely related to mental retardation or to require treatment similar to that required for individuals with mental retardation", as referenced in Welfare and Institutions Code section 4512, is not defined by statute or regulation. Whereas the first four categories of eligibility are very specific (i.e., mental retardation, epilepsy, autism and cerebral palsy), the disabling conditions under this residual, Fifth Category are intentionally broad to encompass unspecified conditions and disorders. There are many persons and groups with sub-average functioning and impaired adaptive behavior. However, the service agency does not have a duty to serve all of them. The Fifth Category does not provide unlimited access to all persons with some form of learning or behavioral disability.

While the Legislature did not define the fifth category, it did require that the condition be "closely related" (Welf. & Inst. Code, §4512) or "similar" (Cal. Code Regs., tit. 17, §54000) to mental retardation. The definitive characteristics of mental retardation include a significant degree of cognitive and adaptive deficits. Thus, to be closely related or similar to mental retardation, there must be a manifestation of qualitative or functional cognitive and/or adaptive deficits which render that individual's disability like that of a

person with mental retardation. This, however, is not a simple and strict replication of all of the cognitive and adaptive qualities or criteria to find eligibility due to mental retardation (e.g., reliance on IQ scores). If it were, the Fifth Category would be redundant. Eligibility under this category requires analysis of the quality of claimant's cognitive and adaptive functioning and whether the effect on his performance renders him like a person with mental retardation.

To have a condition which requires treatment similar to that provided to mentally retarded persons is not a simple exercise of enumerating the services provided to such persons and seeing if claimant would benefit. Many people could benefit from the types of services offered by regional centers, such as counseling, vocational training or living skills training. The criterion is not whether someone would benefit. Rather, it is whether someone's condition requires such treatment.

The statutory and regulatory definitions of "developmental disability" (Welf. & Inst. Code, §4512 and Cal. Code Regs., tit. 17, §54000) exclude conditions that are solely psychiatric in nature. California Code of Regulations, title 17, section 54000, also excludes conditions that are solely physical disorders or solely learning disabilities. Therefore, a person with a "dual diagnosis," that is, a developmental disability coupled with either a psychiatric disorder, a physical disorder, or a learning disability, would still be eligible for services. However, someone whose conditions are just from the excluded categories (psychiatric disorder, physical disorder, or learning disability, alone or in some combination) and who does not have a developmental disability, would not be eligible.

17. Claimant exhibited cognitive deficits before age 18. This is evidenced by the drop in his FSIQ between the ages of 7 and 14 (i.e., 91, 69 and 70). In 1976, claimant's mother informed Dr. Kohn that claimant had cognitive deficits. At age 7, he achieved an FSIQ score well outside the range of mental retardation, albeit his reported subtest scaled scores were extremely low and was deficient in his ability to apply generalize practical knowledge and experience to social situations. In 1976, Dr. Kohn characterized claimant as having "low average intelligence."

When claimant was 13½ years old, the LBUSD school psychologist, Tacy Hunter, reported that claimant had an FSIQ score of 69. However, Ms. Hunter questioned the validity of that score given the scatter between claimant's Verbal and Performance IQ scores. Dr. Whiting reported that, when claimant was 14 years old, he had an FSIQ score of 70 and was diagnosed as having borderline mental retardation.

Although the cause for the decrease in claimant's IQ scores between the ages of 7 and 14 was not established by the evidence, claimant's cognitive and intellectual functioning did fall within the range of mild mental retardation by the time he was 14 years old.

18. However, as set forth in California Code of Regulations, title 17, section 54001, subdivision (b), because an individual's cognitive and/or social functioning are

many-faceted, there are at least seven categories relative to "adaptive functioning" that must be examined. These categories are the same or similar to the categories of adaptive functioning skills listed in the DSM-IV that, to support a diagnosis of mental retardation, requires a finding of significant limitations in at least two such skills. Applying the evidence to the seven listed categories reveals the following:

a. Receptive and expressive language.

On the Illinois Test of Psycholinguistic Abilities that Dr. Kohn administered, claimant achieved a composite score of six years, three months, which was nine months below his chronological age at the time of testing. Dr. Kohn noted that claimant's receptive processes were lower than his expressive processes in the acquisition and use of language. When claimant was in the 7th grade (i.e., grade 7.6), he had a composite language score on the CTBS test of a 5.7 grade equivalent, thereby showing some delay. Tacy Hunter, reported that at age 13½ claimant's speech was understandable and that he always answered a direct question, but initiated very little conversation. Dr. Whiting reported that claimant is able to communicate and interact with others without extreme difficulty. He also noted that claimant appeared to have mild impairment to both his expressive and receptive speech abilities. More recently, claimant appeared to be able to communicate without difficulty when he was interviewed by Dr. Back-Madruga and Dr. Collister. Of particular note was claimant's ability to follow instructions, converse with his evaluators and recognize words such as "audacious," "protuberance" and factitious.

Claimant's communication skills, by themselves, are neither severe nor sufficiently impairing to constitute a developmental disability.

b. Learning.

When she was interviewed by D. Kohn, claimant's mother indicated that claimant crawled at seven months, walked at 10½ months, and was toilet trained at 2½ to 3½ years of age. Although claimant's academic scores were low and, beginning in the 9th grade, he attended special education classes for two to three hours per day,[25] he graduated from high school without having to repeat a grade. He enjoyed going to school.

The evidence shows claimant was not severely impaired in his ability to learn.

c. Self-care.

As a child, claimant's opportunities for self-care were limited. Dr. Kohn reported that claimant was over-dependent and overprotected, and was something of a "mother's boy." However, there is no evidence that prior to age 18 or thereafter, claimant could not dress himself, take care of his personal grooming and hygiene, or otherwise care for

[25] There is no evidence that any of claimant's special education classes were for mentally retarded students.

himself. When Dr. Back-Madruga interviewed claimant in June 2006, she observed claimant to have fair grooming and hygiene. In September 2006, claimant informed Dr. Collister that claimant had resided in board and care since age 18, but attempted to live on his own on two occasions. The first time was in his early 20's, for a short period after graduating from high school. The second time he shared an apartment with a friend for a four year period. Claimant stated that in each instance, "it didn't last" and he returned to living at a board and care facility. Claimant gave no specific reasons for returning to a board and care facility.

Claimant's ability to take care of himself is only very slightly impaired. There is no evidence that he can not complete activities of daily living.

d. Mobility.

Claimant does not have any significant extant mobility problems. However, his mobility is somewhat limited in that although he uses public transportation by himself, he does not have a driver's license.

e. Self-direction:

There is no evidence that, prior to age 18, claimant exhibited substantial functional limitations with respect to self-direction. That is, there was no evidence that claimant could not carry out activities of daily living such as doing his homework and making his needs known, without continuous prompting. On the contrary, his desire to do volunteer work during his senior year of high school demonstrated self-direction. Current potential problems that may be associated self-direction, such as alleged fire-setting, would be the result of a psychiatric condition rather than a developmental disability.

f. Capacity for independent living.

Capacity for independent living is not an adaptive skill that applies to children or adolescents.

As indicated above, claimant has been on her own since age 18. While he resides in a board and care facility, he previously lived on his own for a short period and shared an apartment with a friend for a four-year period. It has not been established that claimant would be incapable of living on his own, if he desired to do so. However, claimant has not demonstrated an ability to manage money, schedule appointments, keep a calendar, or cook meals requiring the measurement of ingredients.

g. Economic self-sufficiency.

Economic self-sufficiency is not an adaptive skill that applies to the assessment of children or adolescents.

Claimant informed Dr. Collister that he had performed volunteer work during his senior hear in high school and performed other volunteer at school. He told Dr. Back-Madruga that he did volunteer work that included cashier work in the student store and cafeteria in high school. Although claimant had never been gainfully employed, it was not established that he could not become economically self-sufficient through some type of employment and SSI funds.

During the four year period that claimant shared an apartment with a friend, claimant was receiving support through Supplemental Security Income (SSI), in an amount not established by the evidence, and through Medi-Cal. He gave his friend money to pay the bills.

19. Based on her interview of claimant's mother, Dr. Back-Madruga reported extremely low scores for claimant in the Vineland-II Adaptive Behavior Scales. It is not known what specific information claimant's mother provided that resulted in the low scores or what role claimant's evolving psychiatric condition contributed to those deficits. The extremely low scores obtained through this test instrument, as reported by Dr. Back-Madruga, does not necessarily correlate with claimant's adaptive functioning before the age of 18 or with other evidence received through a series of direct evaluations of claimant's adaptive functioning.

20. Looking at the foregoing factors in total, there is not enough evidence of significant functional limitation in adaptive functioning to satisfy the second criterion for mental retardation in DSM-IV-TR and to conclude that claimant suffers from a major impairment under California Code of Regulations, title 17, section 54001.

ORDER

WHEREFORE, THE FOLLOWING ORDER is hereby made:

Claimant Timothy L. is not eligible for services and supports from the Harbor Regional Center based on mental retardation or other disabling conditions found to be closely related to mental retardation that require treatment similar to that required for individuals with mental retardation.

April 5, 2007.

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ROBERT S. EISMAN
Administrative Law Judge
Office of Administrative Hearings

This is a final administrative decision, each party shall be bound by this decision. Either party may appeal the decision to a court of competent jurisdiction with 90 days of receiving notice of the final decision. (Welf. & Inst. Code, § 4712.5, subd. (a).)